ADVISORY NO. 3 RE 1999 LEGISLATION
AB 55 and SB 189

References in this Advisory to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended, California Health and Safety Code Sections 1340 et seq. References to "Rule" are to the regulations promulgated pursuant to the Act at Title 10 of the California Code of Regulations, commencing at Section 1300.43.

This Advisory relates to the provisions of AB 55 and SB 189 that are effective January 1, 2001. The Department's requests relating to AB 55 are listed in the Department's letter to health care service plans dated April 5, 2000 in the section relating to SB 189. Those requests have been excerpted and set forth below, with modifications reflecting the information communicated to health plans during meetings with the Department on August 22, 2000 and August 29, 2000, respectively.

Amendments demonstrating compliance with AB 55 and SB 189 are due for filing on November 1, 2000 and should include information sufficient to demonstrate compliance on January 1, 2001.

Application of AB 55

AB 55 (Sections 1374.30 et seq.), as amended by AB 2903, effective January 1, 2000, applies to all full service health plans and all specialized health plans that either: (1) provide services pursuant to a contract with a health care service plan that covers hospital, medical, or surgical benefits, or (2) provide services that involve "the practice of medicine."

Exhibits to be Amended

1. Exhibit E: Narrative Summary of Operations

a. Please file under Exhibit E-1 information that identifies and summarizes the revisions the Plan has made to its various systems and processes to comply with Sections 1374.30, 1374.31, 1374.32, 1374.33, and 1374.35, effective January 1, 2001, and with amendments to Section 1370.4, effective January 1, 2001.

b. Please identify whether the plan has delegated utilization or grievance review processes to contracted providers or other entities. A plan with delegated utilization and grievance review systems should provide an affirmative representation that it has provided revised policies and procedures to its network providers regarding the new requirements relating to processing of denials eligible for IMR pursuant to Section 1374.30, et seq. See Exhibit J, below.

c. The Department will accept a specialized plan's affirmative representation that it does not provide services that involve "the practice of medicine" or services pursuant to contract with a "health care service plan..." Plans that wish to utilize this affirmative representation should include a description of the services offered and supporting explanation and legal authority demonstrating why the services offered do not constitute "the practice of medicine."

d. Assertions that AB 55 is not applicable to a plan because the plan does not make denials based on medical necessity, or because the plan lacks a formal internal utilization review system, may raise issues of concern regarding compliance with Section 1370 and Rule 1300.70. The absence of a plan system for evaluating the medical necessity of requested services can result in a default delegation of such determinations

to contracted providers. Section 1374.30 applies when a denial is made by the plan or one of its contracting providers. A plan asserting that it makes no denials based on medical necessity should include a description of the services offered and explain why its utilization review system does not make determinations of medical necessity. The plan should also provide its affirmative representation that, if it receives a complaint from an enrollee regarding a service declined by a contracted provider, or a request from an enrollee for a service declined by a contracted provider, the plan will comply with the requirements of AB 55.

2. Exhibit J: Quality Assurance Policies and Procedures

a. Please file copies of plan policies and procedures that instruct plan personnel regarding the plan's QA process for oversight of delegated utilization review and grievance review as that may impact independent medical review pursuant to Sections 1374.30 et seq. The QA oversight policies and procedures should be consistent with Sections 1374.30 through 1374.35, and should include:

1. The eligibility criteria, definitions and procedural standards articulated at Section 1374.30(b), (c), (j), (m) and (n);

2. Instructions to plan personnel and providers sufficient to demonstrate that utilization review processes delegated to providers are adequately integrated with the plan's IMR process to assure that no delays that operate to the detriment of enrollees are created by the delegated program, and that the plan has an adequate oversight mechanism.[1]

b. Please file amendments to plan policies and procedures that instruct plan personnel regarding the QA process for oversight of delegated utilization review and grievance review with respect to integration of the Section 1370.4 review process with the Section 1374.30 review process.

3. Exhibits P and Q: Subscriber contracts

a. Please file an exemplar form of subscriber contract that provides, in the section of the subscriber contract that logically relates to resolution of enrollee complaints and grievances, disclosure of information concerning the right to request IMR. [Section 1374.30(i)] If the contract also serves as the EOC, the disclosure should mirror the EOC disclosure. See Exhibit S,T, and U, below. If the contract does not serve as the EOC the contract should disclose: (1) the right of an enrollee to request independent medical review in cases where the enrollee believes that health care services have been improperly denied, delayed or modified by the plan or one of its contracting providers; (2) that a decision not to participate in the IMR process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding

[1] Some provider groups responsible for delegated utilization review and grievance review have developed an internal system for appeal or reconsideration of initial utilization determinations. Such appeals and requests for reconsideration within the provider system must be treated as a "grievance" pursuant to Section 1368 and must not operate to delay an enrollee's right to request IMR pursuant to Sections 1374.30 et seq. Delegated utilization review programs must demonstrate that there will be no "delegated delays" in the grievance process, including IMR.

the disputed health care service; and (3) where additional information regarding the IMR process may be obtained.

4. Exhibits S, T, and U: Evidences of Coverage and Disclosure Forms

a. Please file an exemplar form of evidence of coverage and disclosure form that provides, in the section that logically relates to resolution of enrollee complaints and grievances, a disclosure of the right to request IMR of denials pursuant to 1374.30 et seq. The information provided should be adequate to provide full and fair disclosure as required by Section 1363, including: IMR eligibility criteria; definition of disputed healthcare service; processing timelines, including expedited review; the enrollee's right to submit information in support of the request for IMR; a statement that the enrollee shall not pay for IMR; notice that a decision not to participate in the IMR process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service; a telephone number at which enrollees may obtain further detail regarding the IMR process and how to access IMR. Plans may "bundle" the disclosures required for independent review pursuant to Sections 1374.30 et seq. and 1370.4, so long as the respective eligibility criteria, timelines for notification, etc. are set forth in a manner that will not confuse enrollees.

Set forth below is model language that the Department considers illustrative of full and fair disclosure of the right to IMR and acceptable for the required EOC disclosure. The Department does not require health plans to use this specific language and will review other proposed language submitted by plans for compliance with the Knox-Keene Act.

Independent Medical Review of Grievances Involving a Disputed Health Care Service
(Model Language For EOC Disclosure)

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by the Plan or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by the Plan or one of its contracting providers, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. The Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Eligibility: Your application for IMR will be reviewed by the DMHC to confirm that:

(1) (A) Your provider has recommended a health care service as medically necessary, or (B) You have received urgent care or emergency services that a provider determined was medically

necessary, or (C) You have been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which you seek independent review;

(2) The disputed health care service has been denied, modified, or delayed by the Plan or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and

(3) You have filed a grievance with the plan or its contracting provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow the Plan's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the plan will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within 3 business days.

For more information regarding the IMR process, or to request an application form, please call the Plan's Member Services Department at (___) ___-____.

5. Exhibit W: Grievance Review Process

a. Please file copies of plan policies and procedures that instruct plan personnel regarding the processing of grievances pursuant to new Section 1374.30, et seq. The policies and procedures should be consistent with Sections 1374.30 through 1374.35, and should include:

   1. The eligibility criteria articulated at Section 1374.30(j);

   2. The definitions articulated at Section 1374.30(b) and (c); and

   3. The procedural standards articulated at Sections 1374.30(k) and (n), and 1374.31.

b. Please file amendments to plan policies and procedures that instruct plan personnel regarding the processing of denials pursuant to integration of the Section 1370.4 review process with the Section 1374.30 review process.

c. Please file copies of enrollee denial and grievance correspondence demonstrating compliance with Section 1374.30 et seq. Please include, as applicable, forms of denial and grievance correspondence that will be generated by providers pursuant to delegated utilization and grievance review programs.

The grievance denial/IMR Notice letters should provide detail sufficient to explain fully the IMR eligibility criteria and procedural standards, including but not limited to: the eligibility criteria articulated at Section 1374.30(j); the definitions articulated at Section 1374.30(b) and (c); the procedural standards articulated at Sections 1374.30(k) and (n), 1374.31 and 1374.33, that enrollees do not pay for IMR, and a telephone number and an address at which enrollees may obtain further information regarding the IMR process and how to access the IMR process, and assistance in completing the IMR application form.

The body of the grievance denial/IMR Notice letters should include: (1) a statement of the right to request IMR when the enrollee believes that health care services have been improperly denied, delayed or modified by the plan or one of its contracting providers, (2) a statement that the enrollee does not pay for IMR; and (3) notice that a decision not to participate in the IMR process may cause the enrollee to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service. The remaining detail regarding IMR eligibility criteria, processing times and procedural standards, etc. may be provided in a separate enclosure that is referenced in, and included with, the grievance denial/IMR Notice letter.

d. The Department is currently working to develop a model IMR application form that will be illustrative of the elements needed for processing enrollee requests for IMR. Development of the model IMR application form is not expected to be completed prior to the November 1, 2000 deadline for filing amendments regarding AB 55, but will be made available to plans upon completion. Plans may submit the application forms they have developed, in order to achieve required compliance with Section 1374.30(m). The Department will review and approve these forms, or provide comments requesting amendment of the application form based on Section 1374.30(m). The Department may subsequently request further amendment to a previously approved application form after further review and evaluation.

e. Please file amendments to denial and grievance correspondence demonstrating compliance with Section 1370.4, with respect to its integration with the Section 1374.30 IMR process. Also, please demonstrate that, in addition to the materials that the plan currently provides to enrollees for the purpose of applying for 1370.4 review (e.g. physician certification forms and documentation of eligibility for 1370.4 review) the plan will also provide the IMR application form and pre-addressed envelope described at Section 1374.30(m).